309 MANAGED CARE ORGANIZATIONS

309.1 GENERAL INFORMATION

Introduction

This chapter contains information on processing electronic transactions. This document will identify information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services (HFS).

The intent of this document is to provide information related to electronic submissions by the Managed Care Organizations (MCOs). This document must be used in conjunction with the following documents:

1) National Electronic Data Interchange Transaction Set Implementation Guides and all related Addenda for the following transactions:

   A) 820 – Payroll Deducted and Other Group Premium Payment for Insurance Products
   B) 834 – Benefit Enrollment and Maintenance
   C) 837I – Health Care Claim: Institutional
   D) 837P – Health Care Claim: Professional
   E) 835 – Health Care Claim: Payment/Advice

2) National Council for Prescription Drug Programs Telecommunication Standard Version 1.1 (Batch)

3) HFS Companion Guides provided in Chapter 300 of the Provider Handbook

Business Rules

- File will be sent to and retrieved from HFS via Internet FTP.

- HFS will no longer require claim-level provider affiliation information on encounter data transactions (837I, 837P, NCPDP).

- The “Billing Provider” submitted on encounter data transactions will always be the provider of service. The “Pay-To Provider” will always be a value of “1” (refer to section on individual encounter data transactions).

- When submitting claims to HFS that were previously rejected, the original claim cannot be voided. HFS will not allow a rejected claim to be submitted as a “Void and Rebill”. Only claims that have been paid (accepted) can be voided.

309.2 820 – PAYROLL DEDUCTED AND OTHER GROUP PREMIUM PAYMENT FOR INSURANCE PRODUCTS

309.21 GENERAL INFORMATION

Business Rules

- The 820 transaction will be generated daily but the transaction will only be put in outbound directory when the transaction contains data.

- The 820 transaction will not be generated at the same time as the 834 Benefit Enrollment and Maintenance Monthly Roster transaction.

- This 820 transaction will be the only "remittance advice" created by HFS for capitation payments. An 835 transaction will not be created for the capitation payment.

309.22 TECHNICAL INFORMATION

This section contains information relating to transmitting information to the Department. This section will identify, down to the data element level, anything unique to the Department in regards to the EDI transaction.

Transmission Information

These files will be retrieved from the Department via Internet FTP.

EDI Information:

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IG Page #	Loop	Description	Element ID	Element Name	Remarks
34		820 Header	ST02	Transaction Set Control Number	Will be the last 9-bytes of the NIPS Voucher Number.
36		Financial Information	BPR01	Transaction Handling Code	Will be "I".
37		Financial Information	BPR03	Credit/Debit Flag Code	Will be "C".
37		Financial Information	BPR04	Payment Method Code	Will be "BOP".
41		Financial Information	BPR16	Date	Will be warrant date or EFT date from Comptroller.
43		Reassociation Key	TRN01	Trace Type Code	Will be "3".
44		Reassociation Key	TRN02	Reference Identification	Will be warrant or EFT number from Comptroller.
48		Premium Receivers Identification key	REF01	Reference Identification Qualifier	Will be "14".
49		Premium Receivers Identification key	REF02	Reference Identification	Will be the 16-digit Payee number.
55		Coverage Period	DTM06	Date Time Period	Date range of customary capitation month.
57	1000A	Premium Receivers Name	N102	Name	Will be Payee Name.
57	1000A	Premium Receivers Name	N103	Identification Code Qualifier	Will be "FI".
57	1000A	Premium Receivers Name	N104	Identification Code	Will be 1st 9-digits of Payee number.
63	1000B	Premium Payer's Name	N102	Name	Will be "ILLINOIS MEDICAID".
63	1000B	Premium Payer's Name	N103	Identification Code Qualifier	Will be "FI".

IG Page #	Loop	Description	Element ID	Element Name	Remarks
63	1000B	Premium Payer's Name	N104	Identification Code	Will be "37-1320188".
87	2000B	Individual Remittance	ENT01	Assigned Number	Will be a sequential number starting with 1.
87	2000B	Individual Remittance	ENT03	Identification Code Qualifier	Will be "ZZ".
87	2000B	Individual Remittance	ENT04	Identification Code	Will be the Recipient's 9-digit number as shown on the MediPlan Card, KidCare Card or SeniorCare Card.
88	2100B	Individual Name	NM101	Entity Identifier Code	Will be "QE".
92	2300B	Individual Premium Remittance Detail	RMR01	Reference Identification Qualifier	Will be "AZ".
92	2300B	Individual Premium Remittance Detail	RMR02	Reference Identification	Will be the 6-digit site followed by the applicable rate procedure code. Adjustments will not always have a procedure code in this segment.
95	2300B	Individual Coverage Period	DTM06	Date Time Period	Will be the first of the service month and the end of the service month.
97	2320B	Individual Premium Adjustment	ADX02	Adjustment Reason Code	Will be "52" or "53".

309.3 834 – BENEFIT ENROLLMENT AND MAINTENANCE

309.31 GENERAL INFORMATION

Business Rules

- The 834 transaction will be used in three different capacities. Following is the title as it will be referenced in this document, as well as a brief description of the functionality:
- **Daily Input** – The 834 Daily Input File will be generated by the Managed Care Organization (MCO) and submitted to HFS. This file will contain the MCO's requests for enrollment, disenrollment, site transfer, and gender changes (under age one).
- **Daily Output** – The 834 Daily Output File will be generated by HFS. This file will contain enrollments, disenrollments, site transfers, and demographic changes processed by HFS.
- **Monthly Roster** – This file will be generated by HFS at the end of the month and will contain members enrolled for the following month. No payment, site transfer, or disenrollment information will be included in this file.

- The Daily Output File must be used by the MCOs to track enrollments, disenrollments, site transfers, and demographic changes.
- Member name and demographic changes will only be supplied on the Daily Output File. This information will not be submitted on the Monthly Roster.
- Currently, HFS only captures language information for spanish-speaking and spanish-reading members. When applicable, this information will be included in the monthly roster.
- When applicable, open end dates will be passed as 12/31/9999.

309.32 TECHNICAL INFORMATION

This section contains information relating to transmitting information to the Department. This section will identify, down to the data element level, anything unique to the Department in regards to the EDI transaction.

Control Segments/Envelopes (ISA/IEA, GS/GE, ST/SE)
The Department will limit the number of INS segments to 5,000 per ST/SE. The Department strongly recommends that all incoming transactions follow the same guidelines. The Department intends to follow all other recommendations as set forth in corresponding Implementation Guides. This includes recommendations on how many transaction sets may be within a functional group (GS/GE), and how many functional groups may be within a transmission envelope (ISA/IEA). The Department reserves the right to alter from any of these recommendations at a later date.

Transmission Information

These files will be transmitted to the Department and retrieved from the Department via Internet FTP.

EDI Information:

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Unless otherwise noted, field requirements are for all files.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
28		Beginning Segment	BGN01	Transaction Set Purpose Code	Must be: "00" for original Daily Input File or Daily Output File "15" for resubmission of Daily Input File or Daily Output File "22" for Monthly Roster
29		Beginning Segment	BGN02	Reference Identification	MCO Parent Provider Number
29		Beginning Segment	BGN05	Time Code	Will be "CT" when HFS creates Daily Output File or Monthly Roster
31		Beginning Segment	BGN06	Reference Identification	MCO Parent Provider Number when HFS creates Daily Output File and Monthly Roster and if BGN01 is "15" or "22".
31		Beginning Segment	BGN08	Action Code	2 – Daily (input and output) 4 – Monthly Roster (output)
33		Transaction Set Policy Number	REF02	Reference Identification	MCO Parent Provider Number
34		File Effective Date	DTP01	Date/Time Qualifier	Will be "007" for Monthly Roster.
36	1000A	Sponsor	N102	Name	Must be "ILLINOIS

IG Page #	Loop	Description	Element ID	Element Name	Remarks
		Name			MEDICAID".
36	1000A	Sponsor Name	N103	Identification Code Qualifier	Must be "FI".
36	1000A	Sponsor Name	N104	Identification Code	Must be "37-1320188".
38	1000B	Payer	N103	Identification Code Qualifier	Must be "FI".
38	*1000B*	Payer	N104	Identification Code	First 9 digits of MCO parent provider number
44	2000	Member Level Detail	INS01	Yes/No Condition or Response Code	Must be "Y".
44	2000	Member Level Detail	INS02	Individual Relationship Code	Must be "18".
45	2000	Member Level Detail	INS03	Maintenance Type Code	Must be one of the following values for Daily Input File or Daily Output File: "001" Site Transfer or Gender Change "021" New Enrollment "024" Cancellation or Term "025" Reinstatement or "030" Monthly Roster
46	2000	Member Level Detail	INS04	Maintenance Reason Code	See chart below.
47	2000	Member Level Detail	INS05	Benefit Status Code	Must be "A".
49	2000	Member Level Detail	INS08	Employment Status Code	Must be "FT".

IG Page #	Loop	Description	Element ID	Element Name	Remarks
52	2000	Subscriber Number	REF02	Reference Identification	Must be the Recipient's 9-digit number as shown on the MediPlan Card, KidCare Card or SeniorCare Card.
53	2000	Member Policy Number	REF02	Reference Identification	When BGN08 is 2 (Daily Input File or Daily Output File): New Enrollments – old site zeroes, new site number Site Transfers – old site number, new site number Disenrollments – old site number, new site zeroes When BGN08 is 4 (Monthly Roster), only the current site will be provided.
59-60	2000	Member Level Dates	DTP01	Date/Time Qualifier	Will be "473" and "474" on the Daily Output File. These dates reflect the site begin/end dates, not the Medicaid eligibility begin/end dates.
79	2100A	Member Language	LUI01	Identification Code Qualifier	This segment will be populated on the Monthly Roster when DMG05 is H (Hispanic). Value will always be "LD".
79	2100A	Member Language	LUI02	Identification Code	Value will always be "SPA".

IG Page #	Loop	Description	Element ID	Element Name	Remarks
	2100G	Responsible Person			Daily Output File and Monthly Roster only. Recipient who is the case holder will not have a 2100G segment.
115	2100G	Responsible Person	NM101	Entity Identifier Code	Always “QD”
116	2100G	Responsible Person	NM103	Name Last or Organization Name	Case Last Name
116	2100G	Responsible Person	NM104	Name First	Case First Name
119	2100G	Responsible Person Communications Numbers	PER03	Communication Number Qualifier	Always “TE”
121	2100G	Responsible Person Street Address	N301	Address Information	Case Address
128	2300	Health Coverage	HD01	Maintenance Type Code	001 – Site Transfers (input/output) 021 – Enrollments (input/output) 024 – Disenrollments (input/output) 025 – Reinstatement (output) 026 – Correction (Gender changes input only) 030 – Monthly Roster
129	2300	Health Coverage	HD03	Insurance Line Code	Always “HMO” or “EPO” (MCCNs)

IG Page #	Loop	Description	Element ID	Element Name	Remarks
132	2300	Health Coverage Dates	DTP01	Date/Time Qualifier	Always: 348 – Benefit (site) begin 349 – Benefit (site) end
133	2300	Health Coverage Dates	DTP03	Date/Time Period	Site Begin or End Date

Acceptable Values for INS03 and INS04 on Member Level Detail (Loop 2000)			
INS03	**Maintenance Type Code**	**Acceptable INS04 Values**	**Maintenance Reason Code**
001	Change	25	Change in identifying data elements (age and gender) on Daily Input File or Daily Output File
		XT	Transfer (site transfer) on Daily Input File or Daily Output File
021	Addition	02	Birth (systematic enrollment of newborn) on Daily Output File
		28	Initial enrollment (systematic enrollment of all others) on Daily Output File
		29	Benefit selection (when the Plans sends the enrollment) on Daily Input File
024	Cancellation or Termination	03	Death on Daily Input File or Daily Output File
		07	Termination of benefits (no longer eligible) on Daily Output File
		14	Voluntary withdrawal (all other disenrollments) on Daily Output File
		43	Change of location (change to noncovered county) on Daily Input File or Daily Output File
025	Reinstatement	41	Re-enrollment
030	Audit or Compare	XN	Notification only

309.4 837I – HEALTH CARE CLAIM: INSTITUTIONAL

309.41 TECHNICAL INFORMATION

This section contains information relating to retrieving information from the Department. Additionally, this section will identify, down to the data element level, anything unique to encounter data submitted to the Department in regards to the EDI transaction.

Control Segments/Envelopes (ISA/IEA, GS/GE, ST/SE)
Unless specifically noted, the Department intends to follow all recommendations as set forth in corresponding Implementation Guides. This includes recommendations on how many transactions may be included in any given transaction set (ST/SE), how many transaction sets may be within a functional group (GS/GE), and how many functional groups may be within a transmission envelope (ISA/IEA). The Department reserves the right to alter from any of these recommendations at a later date.

Transmission Information

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EDI Information

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IG Page #	Loop	Description	Element ID	Element Name	Remarks
59		Header	BHT06	Transaction Type Code	Must be “RP” for encounter data claims.
63	1000A	Submitter Name	NM109	Identification Code	Must be your Federal Tax Identification Number.
98	2010AB	Pay-To Provider Secondary Identification	REF02	Reference Identification	Must be “1”.
104	2000B	Subscriber Information	SBR09	Claim Filing Indicator Code	Must be “MC”.

309.5 837P – HEALTH CARE CLAIM: PROFESSIONAL

309.51 TECHNICAL INFORMATION

This section contains information relating to retrieving information from the Department. Additionally, this section will identify, down to the data element level, anything unique to encounter data submitted to the Department in regards to the EDI transaction.

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IG Page #	Loop	Description	Element ID	Element Name	Remarks
65		Header	BHT06	Transaction Type Code	Must be “RP” for encounter data claims.
69	1000A	Submitter Name	NM109	Identification Code	Must be your Federal Tax Identification Number.
107	2010AB	Pay-To Provider Secondary Identification	REF02	Reference Identification	Must be “1”.
112	2000B	Subscriber Information	SBR09	Claim Filing Indicator Code	Must be “MC”.

309.6 NCPDP VERSION 1.1 BATCH

Information regarding this section will be made available in the near future.

309.7 835 – HEALTH CARE CLAIM: PAYMENT/ADVICE

309.71 TECHNICAL INFORMATION

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IG Page #	Loop	Description	Element ID	Element Name	Remarks
45		Financial Information	BPR01	Transaction Handling Code	Will be “H” for encounter data claims.
46		Financial Information	BPR04	Payment Method Code	Will be “NON”.

HFS Error Code	Description	HIPAA Reason Code	HIPAA Remark Code
W61	Recipient Not Enrolled in Designated Plan	109	N52
W63	Invalid Plan Code	38	N52